TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Stacy C. Croft, D.C.

Respondent Name
Hartford Insurance Company of the Midwest

MFDR Tracking Number
M4-16-0006-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the amount paid to us does not meet the recommended allowance as set by the Texas Medical Fee Guideline for the services rendered during this examination."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Modifier 'RE' represents return to work (RTW) and/or evaluation of medical care (EMC). Reimbursement for this service is $500."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2015	Referral Doctor Examination to determine MMI/IR	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Is the insurance carrier's reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 4150, which states, in part, "AN ADDITIONAL ALLOWANCE MAY BE PAYABLE IF A DETERMINATION OF THE IMPAIRMENT CAUSED BY THE COMPENSABLE INJURY WAS ALSO PERFORMED." Review of the submitted documentation finds that an impairment rating was performed of the upper extremity and spine. The insurance carrier's reduction is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation… (C) … (ii) The MAR for musculoskeletal body areas shall be as follows… (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (-b-) $150 for each additional musculoskeletal body area." The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the upper extremity and cervical spine. Therefore, the correct MAR for this examination is $450.00.
3. The total MAR for the disputed services is $800.00. The insurance carrier paid $500.00. Therefore, an additional reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.